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(h) The payments authorized by the preceding Subparagraphs shall be effective with G.S. 108-55A(c) which states:

"(c) The Department shall reimburse providers of services, equipment, or supplies under the Medical Assistance Program in the following amounts:

(1) The amount approved by the Health Care Financing Administration of the United States Department of Health and Human Services, if that Administration approves an exact reimbursement amount;

(2) The amount determined by application of a method approved by the Health Care Financing Administration of the United States Department of Health and Human Services, if that Administration approves the method by which a reimbursement amount is determined, and not the exact amount.

The Department shall establish the methods by which reimbursement amounts are determined in accordance with Chapter 150B of the General Statutes. A change in a reimbursement amount becomes effective as of the date for which the change is approved by the Health Care Financing Administration of the United States Department of Health and Human Services."

(1) To insure that estimated payments pursuant to the preceding Subparagraph do not exceed the state aggregate upper limits to such payments established by applicable federal law and regulation (42 CFR 447.272), such payments shall be cost settled within twelve months of receipt of the completed cost report or December 31, 1996, whichever date is earliest. Hospitals that receive payments in excess of unreimbursed reasonable costs as defined in this Paragraph shall promptly refund such payments. No additional payment shall be made in connection with the cost settlement.

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(i) Disproportionate share payments to hospitals are limited in accordance with The Social Security Act, As Amended, Title XIX section 1923 (g) Limit On Amount Of Payment To Hospital. This includes the 200% special provision for high disproportionate share hospitals as defined by the statutory definition in Section 1923 (g) of the Act.

(j) Subject to the availability of funds, hospitals that: qualify as disproportionate share hospitals under Subparagraphs (a)(1) through (5) of this plan for the fiscal years ended September 30, 1995, 1996 and 1997; operate Medicare approved graduate medical education programs and reported Medicaid costs attributable to such programs to the Division on cost reports for fiscal years ending in 1995, 1996 and 1997; and incur for the 12-month period ending September 30, 1997 unreimbursed costs (calculated without regard to payments under either this Paragraph or Paragraph (k) of this Plan) for providing inpatient and outpatient services to uninsured patients in an amount in excess of two million five hundred thousand dollars ($2,500,000) shall be eligible for disproportionate share payments for such services from a disproportionate share pool under the circumstances specified below:

(1) Qualification for the 12 month period ending September 30, 1996 shall be based on cost report data and uninsured patient data certified to the Division by hospitals on or before September 23, 1996 for fiscal years ending in 1995, in connection with the disproportionate share hospital application process. Qualification for subsequent 12 month periods ending September 30 of each year shall be based on cost report data and uninsured patient data certified to the Division by hospitals on or before September 1 of each subsequent year, for the fiscal year ending in the preceding calendar year.

(2) Any payments made pursuant to this Paragraph shall be calculated and paid no less frequently than annually, and prior to the calculation and payment of any

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disproportionate share payments pursuant to Paragraph (k) of this Plan.

(3) For the 12 month period ending September 30, 1996 a payment shall be made to each qualified hospital in an amount determined by the Director of the Division of Medical Assistance based on a percentage (not to exceed a maximum of 23 percent) of the unreimbursed costs incurred by each qualified hospital for inpatient and outpatient services provided to uninsured patients.

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(4) In subsequent 12 month periods ending September 30th of each year, the percentage payment shall be ascertained and established by the Division by ascertaining funds available for payments pursuant to this Paragraph divided by the total unreimbursed costs of all hospitals that qualify for payments under this Paragraph for providing inpatient and outpatient services to uninsured patients.

(5) The payment limits of the Social Security Act, Title XIX, section 1923(g)(1) applied to the payments authorized by this Paragraph require that when this payment is added to other disproportionate share hospital payments, the total disproportionate share payments shall not exceed 100 percent of the total costs of providing inpatient and outpatient services to Medicaid and uninsured patients for the fiscal year in which such payments are made, less all payments received for services to Medicaid and uninsured patients. The total of all disproportionate share hospital payments shall not exceed the limits on disproportionate share hospital funding as established for this State by HCFA.

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(6) To ensure that the payments pursuant to this Paragraph do not exceed the State aggregate upper limits to such payments established by applicable federal law and regulation (42 C.F.R. 447.272), such payments shall be cost settled within 12 months of receipt of the completed cost report covering the period for which such payments are made. If any hospital received payments, pursuant to this Paragraph in excess of the percentage established by the Director under Subparagraph (j)(3) or (4) of this plan, ascertained without regard to other disproportionate share hospital payments that may have been received for services during the 12 month period for which such payments were made, such excess payments shall promptly be refunded to the Division. No additional payment shall be made to qualified hospitals in connection with the cost settlement.

(7) The payments authorized by this Paragraph shall be effective in accordance with G.S. 108A-55(c) (See page (27) of this plan).

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(k) An additional one-time disproportionate share hospital payment during the 12 month period ending September 30, 1999 (subject to the availability of funds and to the payment limits specified in this Paragraph) shall be paid to qualified public hospitals. For purposes of this Paragraph, a qualified public hospital is a hospital that: qualifies for disproportionate share hospital status under Subparagraphs (a)(1) through (5) of this Plan; does not qualify for disproportionate share hospital status under Subparagraph (a)(6) of this plan; was owned or operated by a State (or by an instrumentality or a unit of government within a State) as of September 16, 1999 through and including September 30,1999; verified its status as a public hospital by certifying state, local, hospital district or authority government control on the most recent version of Form HCFA-1514 filed with the Health Care Financing Administration, U.S. Department of Health and Human Services on or before September 16, 1999; files with the Division on or before September 16, 1999 by use of a form prescribed by the Division a certification of its unreimbursed charges for inpatient and outpatient services provided to uninsured patients during the fiscal year ending in 1998; and submits to the Division on or before September 16, 1999 by use of a form prescribed by the Division a certificate of public expenditures.

(1) The payment to qualified public hospitals pursuant to this Paragraph for the 12 month period ending September 30, 1999 shall be based on and shall not exceed the unreimbursed costs certified to the Division by each such hospital by use of a form prescribed by the Division for inpatient and outpatient services provided to uninsured patients for the fiscal year ending in 1998, to be converted by the Division to unreimbursed cost by multiplying unreimbursed charges times the cost-to-charge ratio established by the Division for each hospital for the fiscal year ending in 1998. Payments authorized by this Paragraph shall be made no less frequently than annually.

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(2) Any payments pursuant to this Paragraph shall be ascertained and paid after any disproportionate share hospital payments that may have been or may be paid by the Division pursuant to Paragraph (j) of this plan.

(3) The payment limits of the Social Security Act, Title XIX, Section 1923(g)(1) applied to this payment require that when this payment is added to other disproportionate share hospital payments, the total disproportionate share hospital payments will not exceed 100 percent of the total costs of providing inpatient and outpatient services to Medicaid and uninsured patients for the fiscal year in which such payments are made, less all payments received for services to Medicaid and uninsured patients for that year. The total of all DSH payments by the Division may not exceed the limits on Disproportionate Share hospital funding as established for this State by HCFA for the fiscal year in which such payments are made.

(4) To ensure that estimated payments pursuant to this Paragraph do not exceed the State aggregate upper limits to such payments established by applicable federal law and regulation (42 C.F.R. 447.272), such payments shall be cost settled within 12 months of receipt of the completed cost report covering the 12 month period for which such payments are made. No additional payments shall be made in connection with the cost settlement.

(5) The payments authorized by this Paragraph shall be effective in accordance with G.S. 108A-55(c).

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(L) Effective with dates of payment beginning October 31, 1996, hospitals that provide services to clients of State Agencies are considered to be a Disproportionate Share Hospital (DSH) when the following conditions are met:

(1) The hospital has a Medicaid inpatient utilization rate not less than one (1) percent and has met the requirements of Paragraph a(1) of this section; and

(2) The State Agency has entered into a Memorandum of Understanding (MOU) with the Division of Medical Assistance (Division) for services provided after October 31, 1996; and

(3) The inpatient and/or outpatient services are authorized by the State Agency for which the uninsured client meets the program requirements.

(A) For purposes of this paragraph uninsured patients are those clients of the State Agency that have no third parties responsible for any hospital services authorized by the State Agency.

(1) DSH payments are paid for services to qualified uninsured clients on the following basis:

(A) For inpatient services the amount of the DSH payment is determined by the State Agency in accordance with the applicable Medicaid inpatient payment methodology as stated in Section 4.19-A of the plan.

(B) For outpatient services the amount of the DSH payment is determined by the State Agency in accordance with the applicable Medicaid outpatient payment methodology as stated in Section 4.19-B of this plan.

(C) No federal funds are utilized as the non-federal share of authorized payments unless the federal funding is specifically authorized by the federal funding agency as eligible for use as the non-federal share of payments.

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(2) Based upon this subsection DSH payments as submitted by the State Agency are to be paid monthly in an amount to be reviewed and approved by the Division of Medical Assistance. The total of all payments may not exceed the limits on Disproportionate Share Hospital funding as set forth for the state by HCFA.

(m) An additional disproportionate share hospital payment during the 12-month period ending September 30, 1999 (subject to the availability of funds and to the payment limits specified in this Paragraph) shall be paid to hospitals that qualify for disproportionate share hospital status under Subparagraph (a) (1) through (5) of this state plan and provide inpatient or outpatient hospital services to Medicaid Health Maintenance Organizations ("HMO") enrollees during the year ending September 30, 1999. For purposes of this paragraph, a Medicaid HMO enrollee is a Medicaid beneficiary who receives Medicaid services through a Medicaid HMO; a Medicaid HMO is a Medicaid managed care organization, as defined in Section 1903(m)(1)(A), that is licensed as an HMO and provides or arranges for services for enrollees under a contract pursuant to section 1903 (m)(2)(A)(i) through (xi). To qualify for a DSH payment under this Paragraph, a hospital must also file with the Division on or before September 16, 1999 by use of a form prescribed by the Division a certification of its charges for inpatient and outpatient services provided to Medicaid HMO enrollees during the fiscal year ending in 1998.

(1) The payment to qualified hospitals pursuant to this Paragraph for the 12-month period ending September 30, 1999 shall be based on charges certified to the Division by each hospital by use of a form prescribed by the Division for inpatient and outpatient Medicaid HMO services for the fiscal year ending in 1998 converted by the Division to cost by multiplying charges times the

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cost-to-charge ratio established by the Division for each hospital for the fiscal year ending in 1998. The payment shall then be determined by multiplying the cost times a percentage determined annually by the Division. The payment percentage established by the Division will be calculated to ensure that the Medicaid HMO DSH payment authorized by this Paragraph is equivalent as a percentage of reasonable cost to the Medicaid Supplemental payment authorized by Paragraph (e) of this State Plan. The payment percentage for fiscal year 1999 is 67.43.

(2) The payment limits of the Social Security Act, Title XIX, Section 1923(g)(1) applied to this payment require that when this payment is added to other disproportionate share hospital payments, the total disproportionate share hospital payments will not exceed 100 percent of the total costs of providing inpatient and outpatient services to Medicaid and uninsured patients for the fiscal year in which such payments are made, less all payments received for services to Medicaid and uninsured patients for that year. The total of all DSH payments by the Division may not exceed the limits on Disproportionate Share hospital funding as established for this State by HCFA for the fiscal year in which such payments are made.

(3) To ensure that estimated payments pursuant to this paragraph do not exceed the State aggregate upper limits to such payments established by applicable federal law and regulation (42 C.F.R. 447.272), such payments shall be cost settled within 12 months of receipt of the completed cost report covering the 12 month period for which such payments are made. No additional payments shall be made in connection with the cost settlement.